

ATTACHMENT 12

Sample Prior Authorization Request Form (PA/RF) to be submitted with the Prior Authorization / Birth to 3 Attachment (PA/B3)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICD						AT	Prior Authorization Number 1234567				
SECTION I — PROVIDER INFORMATION											
1. Name and Address — Billing Provider (Street, City, State, Zip Code) Therapy Group 1 W. Williams Anytown, WI 55555						2. Telephone Number — Billing Provider (XXX) XXX-XXXX 4. Billing Provider's Medicaid Provider Number 12345678		3. Processing Type 161			
SECTION II — RECIPIENT INFORMATION											
5. Recipient Medicaid ID Number 1234567890			6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY			7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555					
8. Name — Recipient (Last, First, Middle Initial) Recipient, Ima			9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F								
SECTION III — DIAGNOSIS / TREATMENT INFORMATION											
10. Diagnosis — Primary Code and Description 783.4 Developmental delays						11. Start Date — SOI		12. First Date of Treatment — SOI			
13. Diagnosis — Secondary Code and Description						14. Requested Start Date MM/DD/YY					
15. Performing Provider Number	16. Procedure Code	17. Modifiers	1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge	
87654321		GO					12	Birth to 3 occupational therapy services			
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.									22. Total Charges		
23. SIGNATURE — Requesting Provider <div style="text-align: center; font-size: 1.2em; font-weight: bold;">I.M. Provider</div>									24. Date Signed MM/DD/YY		
FOR MEDICAID USE									Procedure(s) Authorized:		Quantity Authorized:
<input type="checkbox"/> Approved <div style="display: flex; justify-content: space-around; margin-top: 10px;"> Grant Date Expiration Date </div>											
<input type="checkbox"/> Modified — Reason:											
<input type="checkbox"/> Denied — Reason:											
<input type="checkbox"/> Returned — Reason:											
SIGNATURE — Consultant / Analyst									Date Signed		